Testimony of David L. Williams, Ph.D., FACHE
To the Policy Committee
Of the White House Conference on Mental Health
Services Delivery Barriers and Solutions for People
Who are Aging in Arkansas and the USA

Chair Person and Members of the White House Conference on Aging Policy Committee, thank you for the opportunity to visit with you today.

I will be addressing you from the perspective of a mental health professional and administrator who grew up professionally in the community mental health movement in Austin, Texas, and has spent the last 27 of my 37 years in community-based mental health, substance abuse and mental retardation services here in Northwest Arkansas building community mental health systems of care as CEO of Ozark Guidance, a private non-profit corporation. Per year we serve about 15,000 people and their families and about 2-3% of those we serve in our medical/clinical services are over 65 years of age.

I think I can convey the sense of urgency we have about the gap between the needs of our elders for mental health services and this low utilization rate with some straightforward demographic information. Three of our four Northwest Arkansas counties have populations over 65 that exceed the state average of 14% for this age group and we expect our four-county population of 43,606 elders in 2000 to grow to 64,500 by 2015, a 48% increase. Meanwhile, this 65+ age group continues to have the lowest utilization of our community mental health services proportionate to their presence in our population and is the only age group that is consistently under represented in the 35-year history of Ozark Guidance. If you look closely, you will also find that the underutilization by our growing Latino population's elders is even lower. And, as you might suspect, our urban mix of elders is better than our rural one.

Given that the best estimate prevalence rate of 19.8% for any mental disorder for people over age 55 is similar to that of other age groups, you would expect utilization rates to be similar. But, here in Northwest Arkansas, as is true nationwide, older adults do not get their fair share of mental health care resources. This, coupled with the knowledge that suicide rates are higher among older adults and the unique challenges of late-life onset of some of the most disabling mental diseases, is a great concern to us as we struggle to provide adequate and equitable mental health care to all age groups regardless of anyone's personal financial circumstances.

I want to own that part of the reason this is so reflects as our board's struggle to balance distributive justice in a mental health policy and financing environment in which demands for care far exceed public and private resources. We have prioritized the development of services for seriously emotionally disturbed children and severely, persistently mentally ill adults in their twenties through fifties at the expense of special services for older persons. Because they were not financially sustainable, we have had to close special day treatment and outpatient services for our older consumers and we now fit them into our general and specialty services.

But if you ask me the primary reason our aging population is underserved, in my opinion, it is that our Arkansas situation is a reflection of our nationwide access, quality, affordability and stigma issues associated with mental health services that have been so well documented in Surgeon General Hatcher's 1999 Report and echoed in President Bush's New Freedom Commission Report on Mental Health in 2003.

In short, the major policy and financing variables that are barriers to adequate and equitable mental health care for our seniors are:

1) Our separate, uncoordinated primary care and behavioral healthcare delivery systems,

2) Our over-financing of hospital and nursing home treatment compared to mental health services in home and community-based settings,

3) Our inequity in Medicare and commercial health insurance coverage for mental health services,

4) Our gaps between research findings on effective treatments for mental disorders in older adults and the quality of clinical practices in everyday settings,

5) Our undersupply of both a trained workforce in geriatric mental health care and the full continuum of cost-effective services in most urban and rural communities,

6) Our neglect-by-policy of sufficient prevention and education interventions to reduce the fears that are the root causes of stigma and increase the chances that seniors and their health care givers will recognize and treat mental diseases as readily and effectively as other diseases and conditions.

If we want a 21st Century mental health delivery system that optimally promotes, conserves and restores the mental health of our aging population, we're talking about a system make-over, not cosmetic cover up. This make-over is probably a couple of decades of work, at least, given our country's tendency to make incremental changes in health care policy. But if we want to "jump start" the delivery system revolution so this decade's baby boomers will have a better chance for mentally healthier lives in their golden years, I think there are three policy investments that hold the most promise for a good return for them:

1) Create Medicare and commercial mental health parity with other medical coverage for the full continuum of effective community-based care and the full range of providers and interventions with demonstrated effectiveness in treatment, education and rehabilitation services.

2) Fund a supercharged public mental health campaign for mental health prevention, education and "stigma-busting" services targeted to help the baby-boomers

become as likely to get timely help for mental conditions as other medical conditions.

3) Create financial and technological incentives for primary and behavioral health care providers and delivery systems to integrate their best practices for cost-effective benefits to patients, providers, systems and payers that fosters the total health of the seniors in their care.

Other system changes will need to be addressed strategically over time so someday we will have community-based systems of mental health care for our seniors and all our population that are affordable, accessible, high-quality, consumer-sensitive and attractive, outcome driven and payer satisfying. However, for immediate change in policies that would create better days in our seniors' mental health from the mountains of Northwest Arkansas to our nation's borders in every direction, my three big wishes are for: 1) benefit parity, 2) supercharged mental health education, and 3) incentives for the integration of primary/behavioral health care best practices. These wishes actualized would be quick and great strides in our quest for adequate and equitable mental health services for our seniors in all walks of life. I'm hoping there are some policy Aladdin's somewhere in the White House and Congress who will grant them.

Thank you for the opportunity to testify and the consideration of your attention.